FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046888

Facility Name: Calhoun Nursing & Rehabilitation Center

Address: 1 Myrtle Lane (Number) Hardin (City) 62047 (Zip Code)

County: Calhoun

Telephone Number: (618) 576-2278 **Fax #** (618) 576-2487

IDPA ID Number: 20-1752491001

Date of Initial License for Current Owners: January 1, 2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary F. Eye **Telephone Number:** (716) 662-4955, ext 392

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Gary F. Eye

(Title) Senior VP of Finance of Tara Cares

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,888	3,998	3,271	23,157	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,888	3,998	3,271	23,157	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.30%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date January 1, 2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 3,270

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 1/1 to 12/31/05 Fiscal Year: 1/1 to 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,082	9,968	505	121,555		121,555	(421)	121,134			1
2	Food Purchase		89,333		89,333		89,333	(1,249)	88,084			2
3	Housekeeping	46,037	11,563	20,700	78,300		78,300		78,300			3
4	Laundry	16,666	7,871	8,872	33,409		33,409		33,409			4
5	Heat and Other Utilities			63,913	63,913		63,913		63,913			5
6	Maintenance	26,135	13,025	27,697	66,857		66,857	(114)	66,743			6
7	Other (specify):* See trial balance			2,636	2,636		2,636		2,636			7
8	**TOTAL General Services**	199,920	131,760	124,323	456,003		456,003	(1,784)	454,219			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	855,148	64,746	5,550	925,444		925,444	(8)	925,436			10
10a	Therapy		251	286,714	286,965		286,965		286,965			10a
11	Activities	20,059	1,176	2,398	23,633		23,633		23,633			11
12	Social Services	18,845	12	1,913	20,770		20,770		20,770			12
13	CNA Training											13
14	Program Transportation			477	477		477		477			14
15	Other (specify):* See trial balance			6,424	6,424		6,424	(800)	5,624			15
16	**TOTAL Health Care and Programs**	894,052	66,185	310,676	1,270,913		1,270,913	(808)	1,270,105			16
	C. General Administration											
17	Administrative	100,644		144,504	245,148		245,148	2,574	247,722			17
18	Directors Fees											18
19	Professional Services			12,646	12,646		12,646		12,646			19
20	Dues, Fees, Subscriptions & Promotions			10,558	10,558		10,558	(3,559)	6,999			20
21	Clerical & General Office Expenses	1,038	19,521	23,386	43,945		43,945	(308)	43,637			21
22	Employee Benefits & Payroll Taxes			139,357	139,357		139,357	(802)	138,555			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,967	20,967		20,967		20,967			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			144,040	144,040		144,040		144,040			26
27	Other (specify):* See trial balance			26,465	26,465		26,465	(15,273)	11,192			27
28	**TOTAL General Administration**	101,682	19,521	521,923	643,126		643,126	(17,368)	625,758			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,195,654	217,466	956,922	2,370,042		2,370,042	(19,960)	2,350,082			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center #0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,587	9,587		9,587		9,587			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,623	76,623		76,623	(3,467)	73,156			32
33	Real Estate Taxes			53,110	53,110		53,110		53,110			33
34	Rent-Facility & Grounds			288,843	288,843		288,843		288,843			34
35	Rent-Equipment & Vehicles			4,513	4,513		4,513		4,513			35
36	Other (specify):* See trial balance											36
37	**TOTAL Ownership**			432,676	432,676		432,676	(3,467)	429,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,392	2,392		2,392		2,392			39
40	Barber and Beauty Shops		361		361		361	(78)	283			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* See trial balance			62,009	62,009		62,009		62,009			43
44	**TOTAL Special Cost Centers**		361	108,201	108,562		108,562	(78)	108,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,195,654	217,827	1,497,799	2,911,280		2,911,280	(23,505)	2,887,775			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,177)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,467)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(800)	15		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(325)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,948)	27		24
25	Fund Raising, Advertising and Promotional	(3,559)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,723)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,071)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,566	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,566		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (23,505)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Calhoun Nursing & Rehabilitation Center

ID# **0046888**

Report Period Beginning: **1/1/05**

Ending: **12/31/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non Allowable Marketing Costs	$ (308)	21	1
2	Remove Employee Recognition Program >$35/EE	(802)	22	2
3	Remove Interco Purchased Services Mark Up	(421)	1	3
4	Remove Interco Purchased Services Mark Up	(114)	6	4
5	Remove Barber & Beauty Income	(78)	40	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,723)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center **#** 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(421)	0	0	0	0	0	0	0	0	0	0	(421)	1
2	Food Purchase	(1,249)	0	0	0	0	0	0	0	0	0	0	(1,249)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(114)	0	0	0	0	0	0	0	0	0	0	(114)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,784)	0	0	0	0	0	0	0	0	0	0	(1,784)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(8)	0	0	0	0	0	0	0	0	0	(8)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(800)	0	0	0	0	0	0	0	0	0	0	(800)	15
16	**TOTAL Health Care and Programs**	(800)	(8)	0	0	0	0	0	0	0	0	0	(808)	16
	C. General Administration													
17	Administrative	0	2,574	0	0	0	0	0	0	0	0	0	2,574	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,559)	0	0	0	0	0	0	0	0	0	0	(3,559)	20
21	Clerical & General Office Expenses	(308)	0	0	0	0	0	0	0	0	0	0	(308)	21
22	Employee Benefits & Payroll Taxes	(802)	0	0	0	0	0	0	0	0	0	0	(802)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(15,273)	0	0	0	0	0	0	0	0	0	0	(15,273)	27
28	**TOTAL General Administration**	(19,942)	2,574	0	0	0	0	0	0	0	0	0	(17,368)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,526)	2,566	0	0	0	0	0	0	0	0	0	(19,960)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Calhoun Nursing & Rehabilitation Center** **#** **0046888** **Report Period Beginning:** **1/1/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,467)	0	0	0	0	0	0	0	0	0	0	(3,467)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,467)	0	0	0	0	0	0	0	0	0	0	(3,467)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(78)	0	0	0	0	0	0	0	0	0	0	(78)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(78)	0	0	0	0	0	0	0	0	0	0	(78)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,071)	2,566	0	0	0	0	0	0	0	0	0	(23,505)	45

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See attached schedule detailing information for Schedule VII, Section A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Administrative Services Costs	$ 144,504	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 147,078	$ 2,574	1
2	V		34	Sublease Building & Equip	288,843	Tara Midwest, LLC	0.00%	288,843		2
3	V		10	Consulting Pharmacy Services	3,200	Tara Pharmacy SE, LLC	0.00%	3,192	(8)	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 436,547			$ 439,113	$ * 2,566	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Donald T. Denz	Co-CEO and CFO	See attachment	45.00	***	0.74	1.84	Finance	$ 3,757	17	1
2	Norbert A. Bennett	Co-CEO	See attachment	45.00	***	0.74	1.84	Operations	3,757	17	2
3	Gail M. Polanski	SVP Quality	See attachment	10.00	***	0.74	1.84	Quality Assuranc	5,470	17	3
4		Assurance									4
5	Suzette Wilson	Vice President	See attachment	0.00	***	0.74	1.84	Admissions	3,315	17	5
6											6
7											7
8	*** Compensation paid only through Support Office and allocated share reported in column 7.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,299		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Aurora Cares, LLC d/b/a Tara Cares
Street Address: 3690 Southwestern Boulevard
City / State / Zip Code: Orchard Park, NY 14127
Phone Number: (716)662-4955
Fax Number: (716)662-2529

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative Services Costs	Days	1,260,156	34	$ 8,003,827	$	23,157	$ 147,081	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,003,827	$		$ 147,081	25

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Health Care REIT, Inc.		X	Acquisition of Operating	Interest only	12-31-04	$ 1,191,300	$ 1,191,300	6/30/2018	5.7500	$ 68,441	1
2				Rights	until Maturity							2
3												3
4												4
5												5
	Working Capital											
6	Health Care REIT, Inc.		X	Working Capital	Interest Only	12-31-04	131,793	131,793	12/31/2007	Prime+3	8,182	6
7					with balance to amortize down					10.3900		7
8					evenly in 2007 thru 12/31/04				effective rate at 12/31/05			8
9	TOTAL Facility Related						$ 1,323,093	$ 1,323,093			$ 76,623	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,323,093	$ 1,323,093			$ 76,623	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center **#** 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	53,066	2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	53,110	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	53,110	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002	47,194	10
2003	50,581	11
2004	52,966	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Calhoun Nursing & Rehabilitation Cente COUNTY Calhoun

FACILITY IDPH LICENSE NUMBER 0046888

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

TELEPHONE (716) 662-4955, ext 392 FAX #: (716) 662-4468

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-08-27-200-001-F	PT NE 1/4 S27 T10S R2W	$ 52,965.86	$ 52,965.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,965.86	$ 52,965.86

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services: _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,591 B. General Construction Type: Exterior Brick Frame Wood Number of Stories one

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 269,573
2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: 53,914
4. Dates Incurred: Prior to January 1, 2005

Nature of Costs: Includes capitalized pre-opening salaries, fringe benefits and other costs incurred prior to 1/01/05 and allocated via related organization.
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	696	35	10	35		35	9
10	4 ton Air Conditioning Units (2) & Ductwork			2005	6,400	640	5	640		640	10
11	Maglocks (7), Keypads (7)			2005	4,560	228	10	228		228	11
12	Water Heater 100 gallon			2005	2,275	114	10	114		113	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,931	$ 1,017		$ 1,017	$	$ 1,016	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	106,541	8,570	8,570		VARIES	8,570	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 106,541	$ 8,570	$ 8,570	$		$ 8,570	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 120,472	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,587	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,587	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,586	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Unitime Payroll System	$ 4,922	92
93			93
94			94
95		$ 4,922	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1996	80	1/1/05	$ 288,843	13.5 yrs	1-15 yrs	3
4	Additions							4
5								5
6								6
7	TOTAL		80		$ 288,843 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: 60 day notice *

10. Effective dates of current rental agreement:
Beginning 12/31/2004
Ending 6/30/2018

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 288,840
13.	12/31/2007	$ 288,840
14.	12/31/2008	$ 288,840

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 5,123 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	2,278	$ 145,668	$	2,278	$ 145,668	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		156	6,461		156	6,461	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,629	134,585		2,629	134,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	5,063	$ 286,714	$	5,063	$ 286,714	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 260,172	$	1
2	Cash-Patient Deposits	3,818		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,948)	497,254		3
4	Supply Inventory (priced at cost)	4,050		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,270		6
7	Other Prepaid Expenses	19,860		7
8	Accounts Receivable (owners or related parties)	(2,663)		8
9	Other(specify): Deposits&Non Resident A/R (see TB)	9,984		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 793,745	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,931		15
16	Equipment, at Historical Cost	106,541		16
17	Accumulated Depreciation (book methods)	(9,587)		17
18	Deferred Charges	871,587		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	4,922		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 987,394	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,781,139	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 109,563	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,818		28
29	Short-Term Notes Payable	131,793		29
30	Accrued Salaries Payable	112,752		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,454		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,010		32
33	Accrued Interest Payable	1,152		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	4,534		36
37	Accrued Expenses	106,558		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 560,634	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,191,300		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,191,300	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,751,934	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 29,205	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,781,139	$	48

***(See instructions.)**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center **#** 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,205	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 29,205	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 29,205	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,220,765	1
2	Discounts and Allowances for all Levels	525,838	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,746,603	3
	B. Ancillary Revenue		
4	Day Care	60	4
5	Other Care for Outpatients		5
6	Therapy	187,470	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 187,530	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	78	13
14	Non-Patient Meals	1,177	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	864	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,119	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,467	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,467	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Commissions	766	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 766	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,940,485	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	456,003	31
32	Health Care	1,270,913	32
33	General Administration	643,126	33
	B. Capital Expense		
34	Ownership	432,676	34
	C. Ancillary Expense		
35	Special Cost Centers	64,762	35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,911,280	40
41	**Income before Income Taxes (line 30 minus line 40)****	29,205	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 29,205	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	2,064	$ 47,635	$ 23.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,564	6,776	135,333	19.97	3
4	Licensed Practical Nurses	13,396	13,954	233,415	16.73	4
5	CNAs & Orderlies	38,066	39,985	384,578	9.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,860	2,015	17,552	8.71	9
10	Activity Assistants	352	352	2,506	7.12	10
11	Social Service Workers	1,963	2,062	18,845	9.14	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,064	30,888	14.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,538	5,010	43,792	8.74	15
16	Dishwashers	4,758	5,054	36,402	7.20	16
17	Maintenance Workers	2,118	2,203	26,135	11.86	17
18	Housekeepers	5,463	5,655	46,037	8.14	18
19	Laundry	2,135	2,233	16,666	7.46	19
20	Administrator	2,157	2,229	58,506	26.25	20
21	Assistant Administrator					21
22	Other Administrative	1,817	1,928	22,446	11.64	22
23	Office Manager	2,009	2,105	20,104	9.55	23
24	Clerical	84	84	626	7.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca MDS Coordinator	1,674	1,824	39,528	21.67	32
33	Other(specify) Nrsg Admin Clerical	1,567	1,604	14,660	9.14	33
34	TOTAL (lines 1 - 33)	94,297	99,201	$ 1,195,654 *	$ 12.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	9.5 hrs	$ 365	1-3	35
36	Medical Director	contract	7,200	9-3	36
37	Medical Records Consultant	3.50/bed	565	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	3.50/bed	4,985	10-3	39
40	Physical Therapy Consultant			10a-3	40
41	Occupational Therapy Consultant			10a-3	41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant			10a-3	43
44	Activity Consultant	34.37 hrs	1,913	11-3	44
45	Social Service Consultant	34.37 hrs	1,913	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,941		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Ledder	Administrator	0	$ 58,506
Other Administrative Salaries		0	42,138
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,644

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 144,504
TOTAL (agree to Schedule V, line 17, col. 3)	$ 144,504
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ernst & Young	Accounting&Tax	$ 9,709
Various Legal - See attached detailed listing		2,937
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,646

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,873
Unemployment Compensation Insurance	15,635
FICA Taxes	87,278
Employee Health Insurance	15,149
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hep B Vaccines	1,387
Employee Benefits - Other	3,233
TOTAL (agree to Schedule V, line 22, col.8)	$ 138,555

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,202
Health Care Worker Background Check	1,000
(Indicate # of checks performed)	
Facility Advertising	1,872
Professional License	84
IL Health Care Association	4,400
Non Allowable IL Health Care Assn	(1,687)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,872)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,999

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,620
Seminar Expense	2,347
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,967

**See instructions.

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Calhoun Nursing & Rehabilitation Center # 0046888 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $2,713 net of non-allowable**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,249** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **N/A** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **43,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,177**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

ILLINOIS MEDICAID COST REPORT
EDIT CHECKS

C:\DATAload\[Calhoun Nsg & Rehab Center-2005-0046888.xls]Edits

16-May-06

										Proof	
Schedule V	Page 4	Line 45-4	2,911,280	Must Equal	Schedule XVII	Page 19	Line 40	2,911,280	0	TOTAL Expense Unadjusted
Schedule V	Page 4	Line 45-1	1,195,654	Must Equal	Schedule XVIII	Page 20	Line 34-3	1,195,654	0	Total Salary Expense
Schedule V	Page 4	Line 45-7	(23,505)	Must Equal	Schedule VI	Page 5	Line 37-1	(23,505)	0	Total Adjustments
Schedule XI	Page 12a	Line 70-4	13,931	Must Equal	Schedule XV	Page 17	Line 15-1	13,931	0	Total Bldg Imprs - Fx Asset
Schedule XI	Page 13	Line 75-1	106,541	Must Equal	Schedule XV	Page 17	Line 16-1	106,541	0	Total Equip +Vehicles
	plus	Line 80-4	0							
Schedule XI	Page 13	Line 81-2	120,472	Must Equal	Schedule XV	Page 17	Ln 15-1+	120,472	0	Summary - Total Fx Assets
						plus	Line 16-1			
Schedule XI	Pg 12a	Line 70-5	1,017	Must Equal	Schedule XV	Page 17	Line 17-1	(9,587)	0	Total Accum Depr
plus	Pg 13	Line 75-2	8,570							
plus	Pg 13	Line 80-5	0							
Schedule XI	Page 13	Line 82-2	9,587	Must Equal	Schedule XV	Page 17	Line 17-1	(9,587)	0	Summary - Total Accum Depr
Schedule XI	Page 13	Line 95	4,922	Must Equal	Schedule XV	Page 17	Line 23-1	4,922	0	Cons in Progress
Schedule XII	Page 14	Line 7-4	288,843	Must Equal	Schedule V	Page 4	Line 34-4	288,843	0	Rent Expense-Facility
Schedule XIV	Page 16	Line 14-5	286,714	Must Equal	Schedule V	Page 3	Line 10a-3	286,714	0	PT/OT/ST
and	Page 16	Line 14-8	286,714	Must Equal	Schedule V	Page 3	Line 10a-3	286,714	0	PT/OT/ST
Schedule XV	Page 17	Line 25-1	1,781,139	Must Equal	Schedule XV	Page 17	Line 48-1	1,781,139	0	Assets = Liabilities
Schedule XVI	Page 18	Line 24	29,205	Must Equal	Schedule XV	Page 17	Line 47-1	29,205	0	BS Equity = Equity Detail
Schedule XIX	Page 21	Total A	100,644	Must Equal	Schedule V	Page 3	Line 17 -1	100,644	0	Admin Salaries
Schedule XIX	Page 21	Total B	144,504	Must Equal	Schedule V	Page 3	Line 17 -2	144,504	0	Tara Cares Fee
Schedule XIX	Page 21	Total C	12,646	Must Equal	Schedule V	Page 3	Line 19 -3	12,646	0	Professional Fees
Schedule XIX	Page 21	Total D	138,555	Must Equal	Schedule V	Page 3	Line 22-8	138,555	0	EE Benefits
Schedule XIX	Page 21	Total F	6,999	Must Equal	Schedule V	Page 3	Line 20-8	6,999	0	Dues,Fees, Subs
Schedule XIX	Page 21	Total G	20,967	Must Equal	Schedule V	Page 3	Line 24-8	20,967	0	Travel & Seminars

Schedule XVII, Expenses line 31 through 36 have been entered as "linked" to Sch V; therefore, not included in edit checks above